# All Wales Guidelines

# SAFE AND EFFECTIVE USE OF OPIOIDS FOR CHRONIC NON-CANCER PAIN IN ADULTS

**Welsh Pain Society**
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# WELSH PAIN SOCIETY - ALL WALES GUIDELINES FOR SAFE AND EFFECTIVE USE OF OPIOIDS FOR CHRONIC NON-CANCER PAIN IN ADULTS


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# CONTENT



**Note:** This clinical practice guidelines provides recommendations only and does not require mandatory compliance. It does not replace clinical judgment and individualised, patient-centred decision-making.

# 1. GUIDELINES DEVELOPMENT

The use of opioids for chronic non-cancer pain, including chronic primary pain, has been on the increase. This has become a global phenomenon and Wales is not immune to this.

Wales has the second highest mortality per million population in UK, with 66.9 deaths per million for opioid, heroin, and drug misuse related deaths in 2016[1]. Recent data suggests that this is still an ongoing problem[2].

The Crime survey of England and Wales data from 2017/18, shows 7.2% of adults aged 16 to 59 years had taken a prescription-only painkiller not prescribed to them for medical reasons[3].

There is limited high-quality evidence for the effectiveness of opioids for chronic non-cancer pain[4,5,6]. In spite of this, many patients with chronic non-cancer pain are prescribed and remain on opioids, with little evidence of significant improvement in pain intensity, functionality, or overall quality of life.

Prolonged ineffective use of opioids causes side effects and may cause harm to patients[7,8,9].
Even though there are many published recommendations available, there are no local guidelines for the management of patients with chronic non-cancer pain taking opioids in Wales, applicable to primary, secondary and tertiary care.

The Welsh Pain Society (WPS) is a multi-disciplinary professional organisation which aims to reduce the burden of pain in Wales. Its mission is to promote excellence and equality in clinical services in Wales, influence policies relevant to pain, promote research in pain management, encourage and support education and training for healthcare professionals, increase awareness of the prevalence of pain in Wales and contribute to the national and international pain agenda. It intends to work in co-ordination with different professional bodies and stakeholders in achieving its mission.

As part of its mission to promote excellence and equality in clinical services, an all-members survey on opioid management was undertaken between Oct 2020 and July 2021. The survey identified the need for a guideline/pathway in the management of this group of patients. The results of the survey were presented to the WPS council.

The Welsh Pain Society contacted clinical pain experts from a multidisciplinary background to produce **evidence-based and consensus-based guidelines** to support health care professionals in managing patients with chronic non-cancer pain requiring opioids.

A Guidelines development group (GDG) was formed with a task of producing a **'simple and practical'** guidelines, for health care professionals.

This document went through the process of needs assessment, scope of the document, review of literature including other national/international guidelines, multidisciplinary discussions, drafting, consultation feedback and amendments to incorporate the feedback received from various stakeholders, guideline sign off and publication.

## 2. AIM OF THE GUIDELINE

To guide and support healthcare professionals to prescribe all types of opioids safely, especially the strong opioids in primary, secondary and tertiary care. **This should not be seen as a replacement, but as an extension of the national guidelines on opioids to cater for the local population needs in a simplified and concise way.**

Its intention is to: Improve communication between clinicians and patients about the risks and benefits of opioid therapy; improve safety and effectiveness of opioid therapy, improve function and quality of life for patients, and a reduction in the risks associated with long-term opioid therapy.

**This guideline is divided into three parts to address opioid initiation, maintenance and de-escalation.**

For a successful outcome, there should be a shared decision making strategy with open and honest discussions with the patients throughout these stages. Patients need to be given all relevant useful information and directed towards different useful resources so that they can make an informed decision (Appendix 1, 2, 5).

## 3.OPIOID INITIATION

- Opioids should be reserved for patients who have not responded to non-opioid treatments, and who have defined somatic or neuropathic pain conditions for which opioids have been shown to be effective[10]. All appropriate treatment options involving non-opioid medications and non-pharmacological measures should be tried first before deciding on a trial of opioids[15,16].

- Clinicians should only consider opioid initiation if a meaningful improvement in pain and function is anticipated that outweighs the risks to the patient. Consider not starting opioids unless there is a realistic expectation of benefit.

- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and engagement in life. At the point of initiating opioids, consider how opioid therapy will be discontinued if there is no benefit or benefits do not outweigh risks[10,12].

Strategies for self-management should be encouraged, implemented early, and continued simultaneously.

- Monitor opioid or substance misuse with all relevant information to come to an informed conclusion with regards to risk for Opioid misuse.

- Informed and shared decision making before initiating opioid treatment[9,12] is recommended (Appendix 1, 2, 5).

- From the first initiation, patients must be provided information regarding the indication, side effects, the duration of the trial of opioids, and the de-escalation plan[12,13].

- Potential for de-escalation should be discussed prior to initial prescription of opioids. Patients' must be informed that desecalation of opioids will be condisered when:
  ->there is no significant improvement in pain (at least 30% reduction)[13] or function,
  ->or if there are intolerable side effects,
  ->or if pain has been resolved,
  ->or if risk of harm outweighs benefits,
  ->or when there is evidence of behaviours associated with addiction,
  ->or if evidence of drug misuse or diversion.
- This guideline recommends clear documentation of the de-escalation strategy prior or during initiation of opioids treatement.

- Consider whether an opioid contract may help. If the patient is willing and if this is considered necessary, this should be documented in the patient's notes and uploaded on to Welsh Clinical Portal (WCP) or into Primary Care Record (Appendix 3).

- If the patient is not keen to sign a contract, then an **informed patient agreement is discussed and** whatever discussed and agreed upon should be documented in the notes and loaded on to Welsh Clinical Portal (WCP) or Primary care record.

Discuss with the patient the potential for developing opioid dependency and symptoms suggestive of opioid dependence[14]. If patient agrees, involve family members supporting the patients, and educate them to be aware of these symptoms[14]. Provide the opioid information and opioid safety leaflets (Appendix 1, 2).

Consider initiating a short acting opioid[15], starting with a **lowest dose (5mg Oral Morphine four hourly)**, before increasing **slowly** depending upon the response. After establishing a stable opioid dose, consider converting to an equivalent dose of a prolonged or slow release opioid. **Prescribe the lowest clinically effective dose of opioid[15].**

- Patients must be reviewed 2-4 weeks after initial prescription[13] and then atleast every 6 months once stabilised on opioids. At the initial review at 2-4 weeks, if there is no reasonable benefit do not continue[13,15-17] and stop with gradual reduction.

- Side effects should be monitored and treated appropriately, remaining mindful that the best way of treating side effects might be to de-escalate the medication. Commonly encountered side effects include sedation, dizziness, nausea, vomiting, dry mouth, pruritis and constipation[7]. Encourage the patient to stay well hydrated and prescribe laxatives and anti-emetics at initiation[7].

- Clinicians should use caution when prescribing opioids at any dosage, and should assess evidence of individual benefits and risks when increasing dosage to ≥50 mg Oral morphine equivalent daily dose (MED dose)[15,16].

- Caution with patients prescribed sedatives including benzodiazepines[15] or gabapentinoids[18], patients with renal and liver impairment, frail patients or those aged > 65 years old and patients with history of alcohol, drug, or medication misuse.

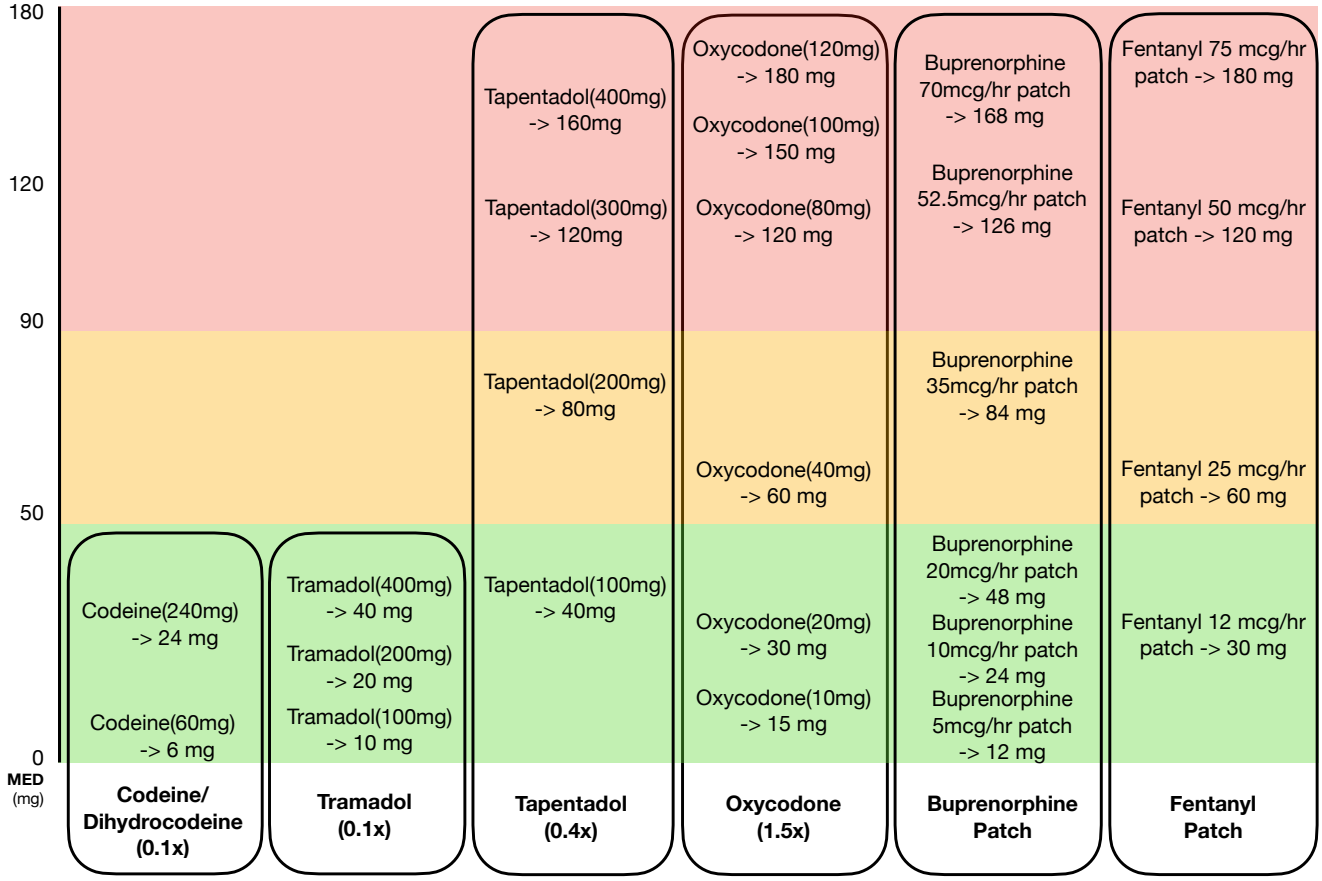
- Central side effects including drowsiness and dizziness tend to improve gradually. Patients should be counselled about the possible effects on driving and other skilled tasks and their legal responsibilities[12].

- The maximum daily dose prescribed should be limited to 90 mg MED[15,16] , **Or any dose increase above 90 mg MED, needs to be justified as the risk of harm increases substantially. At doses above 120 mg MED, the risk of harm substantially increases with no increase in benefit**[15,16].

- Justify the need to go above 90 mg MED as patients who benefit from opioids should not be denied effective opioids. At the same time, the dose should not be escalated when there is not much benefit in order to minimise the risk of increasing harm[15,16] .



**Table 1: Opioid dose risk (Oral Morphine Equivalent Daily Dose (MED)**




- Aim to reduce prescribed doses of sedatives including benzodiazepines[15] or gabapentinoids[18] to the lowest efficacious dose before initiating opioids.

**Initiation Checklist**

Indication appropriate
All non-opioid management options tried
Opioid risk assessment completed
Patient discussion to include:
    Indication, patient's goal, type of opioid, route, dose and side effects, duration of trial, next review, weaning plan if opioids not effective
Effects of opioids on driving discussed
Documentation of all the above along with patient agreement in the notes
Patient information leaflet given

# 4.MAINTENANCE



- Once stabilised on long-acting opioids, patients must be reviewed regularly, atleast every 6 months. This review should happen even if the patient feels that they are getting response from opioids with acceptable side-effects.

- Review the effectiveness of pain control and functionality and ask about side-effects. Opioids can be continued if there is evidence of benefit to pain control and/or improvement in functionality and engagement in life, and that such benefit outweighs side-effects or risks.

- This review can be done at primary care or at secondary care (for complex pain issues like patients with difficult pain control, high doses of opioids, complex mental health issues). Ideally the review should be by the same clinician[15].

- Patients must be reminded of the effects of opioids on driving and the legal situation pertaining to such (Appendix 5).

**Opioid Rotation:**

- Consider opioid rotation if pain is responsive to opioids but dose titration is difficult due to side effects (Table 1).

- If switching from one opioid to another, start the new opioid at 25% lower equivalent dose [19,20] ( Appendix 5). This can be 25-50% lower in frail or elderly patients >65 years or with impaired renal or liver function, or co-prescribed with other sedatives including benzodiazepines or gabapentinoids.

- Patients need to be regularly reviewed for long-term endocrine side effects including hypogonadism or adrenal insufficiency[21]. Symptoms of opioid induced hypogonadism include loss of libido, fatigue, depression, anxiety, loss of muscle strength and mass, impotence in men,

**Maintenance Checklist**

Review of indication and is still appropriate
Improved pain and/or Functionality
Side effects within tolerable levels
Any role of non-opioid interventions?
Is the dose reached above 90 mg MED for review for de-escalation?
If opioid switch-dose of the new opioid 25% less the MED of the old opioid (25-50% elderly & high-risk group)
Effects of opioids on driving discussed
Time of next review

menstrual irregularities and galactorrhea in women[21]. Consider referral to endocrinology on a case by case basis if appropriate.

- If the patient has not derived substantial analgesic benefit at a dose of 90 mg MED, or risk of harm outweigh benefits at any MED, de-escalation should be initiated. It is possible to de-escalate at doses less than 90 mg MED if clinically indicated or has not shown substantial benefit.

- **If you need to increase above 90 mg MED, justify your decision, as the risk of harm increases substantially[15,16] beyond this dose.**

## 5. DE-ESCALATION

- Clinicians must consider starting de-escalation of opioids if: [11,14,20]
  - There is no improvement in pain or function
  - Patients develop intolerable side effects
  - Pain has resolved
  - There is greater risk of harm as compared to benefits
  - There is evidence of drug-seeking behaviour, or drug misuse or diversion.
- Discuss with the patient the treatment goals and the effectiveness of opioids in achieving this. Listen to patient's beliefs and concerns[14,19,22] and address them.

If there is an opioid contract/informed agreement with patient, discuss what was agreed with respect to continuation/de-escalation or opioid withdrawal within the contract[9].

**Non-pharmacological management strategies**

National Exercise Programme
Acupuncture
Swimming
Education Programmes for Patients (EPP Cymru)
Pain Management Programme (PMP)
Referral to social prescribers or local area co-ordinators
Psycological interventions and support
Pilates
Mindfulness
Listening to music
Reading books of interest

- **Key points for a successful outcome:**

**-> Patient engagement and subsequent agreement with the de-escalastion is key to success and patient education is vital.**

**-> Aim for an individuallised plan using shared decision making[14] with patient educated appropriately.**

**->Educate the patient on the need for de-escalation, benefits of tapering and the harm of continuing of opioids.**

Provide support[14,22-25] and signpost them towards different resources including peer support, national and local support groups to help with this[14,23] (Appendix 5).
Consider rationalising to a single opioid if possible[11] and prescribe regular and not PRN doses[11].

Advice about non-pharmacological management strategies and educate about self-management.

Attending **Pain Management Programmes (PMP)** enable people to manage their pain better, and does not aim to cure pain. This is an out-patient group based intervention run by a Multi Disciplinary Team (MDT) of health professionals including physiotherapists, psychologists, clinical nurse specialists, pharmacists and chronic pain consultants. There is evidence to support that attending a PMP will improve quality of life, physical function, psychological distress, pain interference and pain self–efficacy[26].

Physiotherapy and physical exercise applied in chronic conditions within important parameters such as frequency, duration and intensity has been shown to decrease pain and improve physical function[27]. This is most successful when tailored to the individual, progressed slowly and account for physical limitations. Prolonged physical inactivity is likely to contribute to an increase in all chronic conditions[27].

**Psychological interventions and support** can assist people with coping and adaptation to pain. A variety of factors associated with good adjustment and effective coping and management of pain have psychological underpinnings. Psychological and behavioural treatments for pain can include cognitive behavioural therapy (CBT), Acceptance and Commitment Therapy (ACT), Mindfulness Based Stress Reduction (MBSR), and other therapeutic approaches, with the aim of reducing distress and suffering,

boosting self-regulation, reducing pain intensity, and improving physical function and health-related quality of life[28] with evidence strongest for CBT and ACT approaches[29].

**->Patients may be anxious that they may not be able to cope with pain if the opioids are reduced and about the withdrawal symptoms. Reassure and educate on the support available.**

Educate about the acute flare ups during the de-escalation process and the management of these flare ups using non-opioid analgesics and non-pharmacological strategies[15].

Discuss how to identify withdrawal symptoms and the treatment available for managing them (Appendix 6, 7). Withdrawal symptoms are characterised by shivers, diarrhoea, insomnia, sweating, body aches, widespread or increased pain, irritability and agitation, and nausea and vomiting. Other signs and symptoms include restlessness, lacrimation, rhinorrhoea, yawning, mydriasis, palpitations, anxiety, hyperkinesia, tremor, weakness, anorexia, abdominal cramps, and increased blood pressure, respiratory rate, and heart rate[9].
Engage with family and friends to support them if the patient is in agreement with this.

Discuss about an increased risk of overdose if previous high dose of opioids is taken following tapering as their opioid tolerance is reduced[11].
Consider the possibility of hyperalgesia if a patient on long-term opioid therapy presents with increased sensitivity to pain[9] (Opioid Induced Hyperalgesia). This requires slow reduction in opioid dose[9].

->There are patients who are willing, and co-operative and there are patients who are unwilling and not are ready[20,22] for de-escalation.

- **If patient agrees to tapering: -** *How fast to achieve this?*

There should be an individualised plan with rate of reduction discussed and which is acceptable to the patient[14].

**Fast tapering** for patients on opioids for less than 3 months (Ex-Post-operative etc): reduce opioid dose by 10% of the current dose each week[20]. Reduce the current dose upto 10% in the initial weeks, and then increasing the reduction weekly if tolerable. The starting de-escalation dose can be further lowered if the patient is unable to tolerate the withdrawal symptoms.

Fast de-escalation should be considered if the side effects from opioids are severely compromising patient safety[14].

**Slow tapering** (On opioids longer than 3 months (Chronic pain patients): reduce opioid dose by 10% of the current dose each month[15]. Reduce the current dose upto 10% in the initial months, and then increasing the reduction monthly if tolerable. The starting de-escalation dose can be further lowered if the patient could not tolerate the withdrawal symptoms.

Initiate treatment for withdrawal symptoms if patient develops them (Appendix 8). Review the patient on a regular basis every month. Manage acute flare ups with non-opioid analgesics and non-pharmacological strategies.

Where symptoms become distressing or reoccur, distinguish between withdrawal symptoms or re-emergence of symptoms for which patient is on opioids. Delay or try smaller dose reduction in these situations[14,15].

If there is good progress with tapering, continue until the opioid is completely stopped. If not possible to achieve complete cessation, a reduction to achieve **lowest effective dose** may still be considered as a positive outcome.

It may take a few months to feel normal in relation to pain, anxiety and mood changes after reducing or completely stopping opioids.

**Challenges with tapering:**

- Increased pain, withdrawal symptoms, previous drug use disorder: Consider pausing, reduction and re-evaluate.
- Reassess, support and treat withdrawal symptoms (Appendix 7).
- Support may be needed from Pain specialists, Psychology, Mental health, and Substance Abuse teams[16,20] before reattempting to taper.

Patients who are unable to complete the taper may be maintained at a lower opioid dose, if they are compliant with the treatment agreement[11]. Make a plan to attempt dose de-escalation at a later date[14] and schedule frequent reviews.[14,16]

Seek psychology and mental health support for patients with predominance of psychological and mental health issues[16,20].
Seek addiction services support for cases with signs of addiction[16,20] or dependence. Liase with them where appropriate to see what direct or consultative support may be available.

- **If the Patient does not agree with tapering:**

Reassess the patient's belief, goals, and reason for resistance[17,20,22]. Educate the patient on the side effects and benefits of de-escalation. **Be sensitive to the use of terminology avoiding words that can suggest blame[14] or Judgement**. Assess for drug/opioid misuse or diversion.

Patient may be anxious that they may not be able to cope with pain if the opioids are reduced, and also about the withdrawal symptoms. Reassure and educate on the support available. Signpost them towards useful resources (Appendix 5).

Be prepared for queries about prescribing decisions made previously. Explain that our understanding of the balance of risks and benefits of a medicine can change over time[14].

Discuss the management of acute flare ups using non-opioid analgesics and non-pharmacological strategies. Also, discuss the management of withdrawal symptoms (Appendix 7).

**-> Forceful de-escalation can be detrimental as it can lead to increased illicit drugs, alcohol abuse and deterioration to mental health[21]. Continue to engage and educate the patient on the benefits and need for de-escalation.**

Seek psychology and mental health support for patients with predominance of psychological and mental health issues[16,20].

Seek addiction services support for cases with signs of addiction[16,20] . Liase with them where appropriate to see what direct or consultative support may be available.

If a shared decision making is not reached, follow General Medical Council guidance advice on 'handling patient requests for medicines you do not think will benefit them'[14,30].

**Acute post-operative transition period:**

For patients who are **not** on opioids before surgery, prescription of opioids should be for 7 days only at the time of disharge from hospital. If the patient needs opioids beyond one week, they should be reviewed on a regular basis before re-prescribing.

Patients who are **not** on opioids before surgery, should not require opioids for post-operative pain more than 3 months after surgery. **Seek a surgical review if any patient is still experiencing pain requiring opioids > 3 months**[31]**.**

**De-escalation Checklist**

Opioids not effective with no improvement in pain or functionality
Intolerable side effects
Aim to reach agreement with shared decision making
Assessment to see whether patient needs support from specialist/MDT
Appropriate de-escalation strategy

# 6.SUMMARY

**All Wales Guidelines - Safe and Effective Use of Opioids for Chronic Non-Cancer Pain in Adult**

**Initiation**

**Initiation Checklist**

- Indication appropriate
- All non-opioid management options tried
- Opioid risk assessment completed
- Discuss the following with the patient:
  - Indication, patient's goal, type of opioid, route, dose and side effects, duration of trial, next review, weaning plan if opioids not effective
- Effects of opioids on driving discussed
- Documentation of discussions and the plan agreed by the patient
- Patient information leaflet given

**2-4weeks**

Effective → **Continue & review every 6 months**

Not effective → **Discontinue**

**Maintenance**

**Maintenance Checklist**

- Review of indication and is still appropriate
- Improved pain and/or Functionality
- Side effects within tolerable levels
- Any role of non-opioid interventions?
- Is the dose reached above 90 mg MED for review for de-escalation?
- Justify doses above 90 mg MED
- If Opioid switch-dose of the new opioid 25% less then MED of the old opioid (25-50% less for elderly & high-risk group)
- Effects of opioids on driving discussed
- Time of next review

**De-escalation**

**Consider de-escalation**

- No improvement in pain or function
- Intolerable side effects
- Resolved pain
- Harm > benefits
- Drug seeking behaviour

**On opioid < 3 months**
**Severe side effects**
**Compromising patient's safety**

→ **Fast de-escalation**
Reduce 10% every week
Monitor and treat withdrawal symptoms

**On opioid > 3 months**

→ **Slow de-escalation**
Reduce 10% every month
Monitor and treat withdrawal symptoms

Note: De-escalation can be started at lower doses initially and if patient cannot tolerate withdrawal symptoms.
Patient education and engagement for shared decision making.
Consider non-pharmacological management strategies and specialist support.

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# Taking Opioids for Pain

### How do opioids work?

Opioids provide pain relief by acting on areas in the spinal cord and brain to block the transmission of pain signals. Opioids are considered to be some of the strongest painkillers available and are used to treat pain after surgery, serious injury and cancer. Opioid drugs can help manage some but not all types of chronic pain.

### How are opioids taken?

Opioid medicines come in many different forms, such as injections, tablets, capsules, liquids, and patches.

### When should I take my opioid medicines?

For continuous long-term pain you may be given a slow-release tablet or an opioid skin 'patch' which gives a steady level of medicine in the blood that is the best way to manage pain. Your health-care team will adjust the dose to give you pain relief most of the time, and so you don't get too many side effects. Fast-acting opioid medicines and opioids that can be injected are not very useful for managing continuous pain.

### What dose of opioid should I take?

The correct dose of any medicine is the lowest dose that produces a noticeable benefit. It is not usual to get complete relief of pain from opioids.

You should always take the correct dose of prescribed medicines. If you feel the dose isn't enough, or if the side effects interfere with your life, you should discuss this with your healthcare team.

### How long will it take to work?

This depends on the form that has been prescribed. For long-term pain tablets or skin patches are prescribed most commonly. Fast acting tablets may be used when you first start trying opioid treatment. They may work within an hour and last for around three to four hours. Slow release tablets or patches take longer, up to two or days to begin to have any noticeable effect.

### What are the possible side effects?

When you first start taking opioids you can get some side effects, which usually stop after a few days. These include:

- feeling dizzy
- feeling sick (nausea)
- being sick (vomiting)
- feeling sleepy
- feeling confused

Sometimes these side effects can go on for longer than a few days. Your health-care team may give you some other medicines to help, such as anti-sickness tablets.

If pain has affected your sleep, opioids may help you to recover your normal pattern of sleep, but they should not make you drowsy in the daytime.

Opioid medicines can cause some problems when you take them for long periods of time. These problems include:

- constipation*
- itching
- weight gain
- lack of sex drive
- difficulty breathing at night**

** This is a common problem when taking opioids and does not tend to go away the longer you take opioid medicines. You may need to try laxatives to treat constipation. If you experience a lot of side effects your team may suggest changing to another opioid drug.*
*** This is most common if you are overweight and if you snore heavily. If you have a condition called obstructive sleep apnoea it may not be safe for you to take opioids.*

# Taking Opioids for Pain

### Can I drive when I'm taking opioids?

The law in the UK allows you to drive if you are taking prescribed opioid medicines in accordance with the instructions from your prescriber (including what your prescriber advises you about driving safely). You should never drive if you feel unsafe. Your ability to drive may be affected by other medicines you are taking in addition to opioids, whether you feel tired and by your pain. You are responsible for making sure you are safe on each occasion that you drive.

The law on drugs and driving in the UK changed in 2015. If your driving is impaired for any reason, including taking medicines, it is illegal to drive. It is also now illegal to drive when you are taking opioid medicines without them being prescribed, even if you are not impaired. Preparation for the new drug driving laws involved extensive scientific research to investigate what effect opioid drugs have on ability to drive safely. We now know that if a person is taking more than 220mg of morphine a day they are likely to have a blood level of the medicine which impairs them nearly as much as someone who is over the legal limit of alcohol. All opioid medicines have the potential to impair driving and your prescriber will advise whether the dose of opioid you are taking is likely to impair you. If you are taking a high dose of opioid your prescriber will advise you that you are probably not safe to drive and will document this in your medical notes.

The doses of opioid medicine that are likely to affect your driving are quite high and are above the level that we know is safe and effective for pain treatment.

It is unsafe to drive in the first few days after starting an opioid and for a few days after dose change (up or down). Drinking alcohol reduces the amount of opioid medicine you can take and drive safely so do not drive if you have drunk alcohol and taken opioid medicines.

### What if I forget or miss a dose?

Take it as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your medication as normal.

Do not take two doses together.

### Can I take this medicine long-term?

While opioids can have a positive benefit for some people living with long-term pain they can have serious consequences when they are not providing sufficient benefit or are being taken in a manner that was not intended. It is important to consider the risks and benefits of continued opioid therapy with your prescriber on a regular basis. Recent medical literature suggests that the risks to your health increase significantly when prescribing opioids at high doses for a long period of time. If you take opioid drugs for many months or years it can affect your body in a number of ways. These problems include:

- reduced fertility
- low sex drive
- irregular periods
- erectile dysfunction in men (the inability to keep an erection)
- reduced ability to fight infection
- increased levels of pain

If you are worried about any of these problems, please discuss this with your health-care team. Your team will be able to tell you whether you are at risk of developing these problems.

Everyone prescribed opioid medicines in the long-term should have them reviewed by their prescriber at regular intervals. If this does not happen ask your General Practitioner.

If you want to try reducing your dose, you should discuss this with your doctor and bring the dose down slowly.

Many people find that after a few months they can reduce their opioid dose without the pain increasing. Many individuals are able to reduce gradually their opioid dose and find that their pain is no worse. As fewer side effects are experienced, quality and enjoyment of life can improve. All of this contributes to greater physical fitness.

# Taking Opioids for Pain

### Can I drink alcohol?

Alcohol and opioids both can cause sleepiness and poor concentration. You should avoid alcohol completely when you first start on opioids or when your dose has just been increased. If you are taking opioids, you should avoid alcohol if you are going to drive or use tools or machines. When you get on a steady dose of opioid, you should be able to drink modest amounts of alcohol without getting any extra unusual effects.

### Will my body get used to opioid medicines?

Opioids can become less effective with time (this is called tolerance) meaning your body has got used to the pain relieving effect of the medicine. You can also become dependent on opioid medicines (dependence). This means that if you stop taking the drug suddenly, or lower the dose too quickly, you can get symptoms of withdrawal. If you run out of medicine, you can experience the same symptoms that include:

- tiredness
- sweating
- a runny nose
- stomach cramps
- diarrhoea
- aching muscles

### What about addiction to opioids?

It is rare for people in pain to become addicted to opioids. People who are addicted to opioids can:

- feel out of control about how much medicine they take or how often they take it
- crave the drug
- continue to take the drug even when it has a negative effect on their physical or mental health

We do not know exactly how many people get addicted when they are taking opioids for pain relief but it is very uncommon. It is more common if you have been addicted to opioids (including heroin) or to other drugs (or alcohol) before. Addiction may be more common in people with severe depression or anxiety. This does not mean that if you have had an addiction problem before or you are very depressed and anxious you will become addicted. It only means that you are more likely to become addicted than someone who has not had these problems. Most people do not become addicted.

So, if you have had a problem with drug or alcohol addiction in the past this doesn't mean that you cannot take opioid medicines for your pain. However, your health-care team will need to know about your past or current drug-taking to prescribe opioids safely and to help you watch out for warning signs.

### What if I want to stop taking an opioid?

Do not stop taking your opioid suddenly, you may experience withdrawal symptoms. Speak to your healthcare professional (doctor, nurse, pharmacist) who will be able to supervise a gradual reduction.

### Is there anything else my prescriber needs to know?

- If you are allergic to any drugs or medicines
- If you are taking any other medicines or herbal medicines
- If you are pregnant or breast feeding, or if you are planning to become pregnant in the future
- If you have a kidney problem
- If you have or have had a history of excessive alcohol use, recreational drug use or addiction to prescribed or over-the-counter medication

*Opioids Aware 2016. Faculty of Pain Medicine www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware*

https://www.gov.uk/guidance/opioid-medicines-and-the-risk-of-addiction

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Medicines & Healthcare products Regulatory Agency

MHRA

# OPIOID MEDICINES AND THE RISK OF ADDICTION

This safety leaflet is to help support you in using opioid medicines safely. Please keep it in a safe place.

Patients, family, friends, and carers can play an important role in the safe use of these medicines and in reducing the risk of harm. Please share this information with them.

## What are opioid medicines and what's the risk with them?

Opioids are a type of medicine that help relieve pain. They are very effective over short periods, to relieve moderate to severe pain. They are also sometimes prescribed for long periods, to relieve pain in serious conditions. Examples of opioids include codeine (including co-codamol) tramadol, fentanyl and morphine.

Opioids have a serious risk of **addiction,** especially with long-term use. The person who prescribed an opioid or your pharmacist should explain how long it is safe for you to take your medicine for.

For further information on using opioids safely, and a full list of possible side effects, read the Patient Information Leaflet (PIL) that came with your medicine, and keep it handy.

## How can I take my opioid medicine safely?

Only take the medicine as directed.

- **Do not** increase the dose or take an extra dose.
- **Do not** take any other medicines that contain opioids to "top up" your pain relief.
- **Do not** take opioid medicines if you are pregnant without health professional advice.

**Do not do any of these without advice** from the person who prescribed your medicine, or from a pharmacist. Taking more than you should can lead to overdose.

**Babies born to women who took opioids** during pregnancy may need to be carefully monitored for withdrawal effects after birth. Talk to your doctor or midwife if you are worried.

If you have any questions about your opioid medicine or side effects, or if you do not understand how to take your medicine, **talk to** the person who prescribed your opioid medicine or to a pharmacist. **Keep talking** to them about your pain – there may be different treatments that can help.

- **Do not allow others** to take any opioid medicines given to you. Your medicine has been prescribed or specifically recommended for you by your doctor or pharmacist and can be dangerous if taken by other people – it could even cause fatal overdose.
- **Always keep medicines out of sight and reach of children.**

## How do I know if I'm becoming addicted?

Addiction can happen gradually. It can make you feel that you are no longer in control of how much medicine you need to take or how often you need to take it. You might feel that you need to carry on taking your medicine, even when it doesn't help to relieve your pain.

If your pain is becoming difficult to manage, **talk to your doctor.** Your body may have stopped sensing the pain-relieving effect of your opioid. This is called **'opioid tolerance'.** It could be an early warning sign that you are at risk of becoming addicted.

Turn over for other signs of addiction >

This sheet has been produced by the Medicine and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health and Social Care. This information should be used as part of a discussion of the risks with a doctor, nurse, or pharmacist. Keep it safe in case you need it

**Signs that you may be addicted to opioids** include:

- Craving for the medicine
- Feeling that you need to take more medicine than prescribed, or more than instructed on the pack – even though the medicine is causing unwanted effects on your overall health (for example, if you have noticed some of the withdrawal side effects in the next section)
- Feeling that you need to take additional medicines containing opioids or other pain relief medicines to achieve the same relief
- Taking opioid medicines for other reasons than pain: for instance, 'to stay calm' or 'help you sleep'
- Experiencing withdrawal side effects when you stop taking the medicine suddenly (see below).

**If you notice any of the above, talk to your doctor or a pharmacist.**

## How can I safely stop taking my opioid medicine?

If you have been taking your opioid medicine for a long time, **do not stop taking it suddenly** as this may cause unpleasant withdrawal side effects. It is important to get the right help and support when you are ready to stop taking your medicine.

**Talk to your doctor, nurse or a pharmacist**. They will be able to help you to come off your opioid medicine slowly to reduce unpleasant withdrawal side effects. Safely coming off opioids can take a long time. Every person is different. Take any unused opioids back to a pharmacy for safe disposal.

**Withdrawal side effects** may include a combination of the following:

- Shivers
- Diarrhoea
- Difficulty sleeping
- Sweating
- Widespread or increased pain
- Body aches
- Irritability and agitation
- Nausea and vomiting

If you experience any of these, talk to the person who prescribed your medicine or a pharmacist.

## What may happen if I have taken too much opioid medicine?

Taking too much opioid medicine is called an overdose, whether it's intentional or not. This can be very serious and may cause death.

**Some of the signs of an overdose** include:

- Confusion or hallucinations
- Slurred speech
- Lips or fingernails are blue or purple
- Poor coordination or balance
- Unresponsive or unconscious
- Heavy or unusual snoring
- Difficulty breathing or no breathing
- Very small pupils in the eyes

Your family, friends, and carers should know these signs so they can take immediate action.

**If you think that you or someone else has taken too much of their opioid medicine, dial 999 immediately.**

If you think you are experiencing any side effects of your opioid medicines, you can report these directly to the Medicines and Healthcare products Regulatory Agency at www.gov.uk/yellowcard, via the free apps ('Yellow Card Scheme' in the Google Play Store or 'Yellow Card – MHRA' in the Apple App Store), or by phoning the free phoneline (0800 731 6789).

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# Appendix 3 Opioid Contract

Opioids (a morphine-based (opioid) for pain relief) are the next step in the treatment of your chronic pain as pain relief and/or your other goals have not been met with other forms of treatment.
I, (Insert your name) .....

1. have read and understood the information given to me about the risks and benefits of taking opioid medication.
2. understand that when I take opioids, it may affect driving or operation of machinery. If I feel drowsy, confused or am somehow affected by this medication, I should not do things that would endanger other peoples' life.
3. agree to comply with the dosage prescribed and will not increase or decrease this dose without first consulting the Pain Clinic consultant or my GP.
4. agree not to take this medication in any way other than that which has been advised by my doctors.
5. agree to only obtain my prescription from one source: Pain Clinic consultant or my G.P and attend for regular review.
6. agree to tell the Pain consultant or GP about any medications, herbs, and dietary supplements that I may be taking as some of these can affect the safety and effectiveness of opioid medications.
7. understand the addictive potential of opioids and agree to keep a pain diary.
8. agree to set goals with my doctor/pain team. If an opioid is not the right medicine for me, I understand that it will be discontinued.
9. agree to keep my medicine safely and not share with others. Should my opioid medication get lost or stolen, it will be my doctor's decision whether another prescription will be issued.

| | Name & signature | Date |
|---|---|---|
| Patient | | |
| Legal guardian, power of attorney or carer (where patient cannot sign) | | |
| Consultant/GP | | |
| | | |
| Drug prescribed | | |
| Dosage prescribed/advised | | |
| Date treatment commenced | | |
| Treatment Goal | | |
| Review OPA/GP appointment date | | |

# Appendix 4 Opioid Equivalence

## Approximate equi-analgesic potencies of opioids for oral administration

*(Reviewed August 2020 to reflect current BNF figures)*

| | Potency | Equivalent dose to 10mg oral morphine |
|---|---|---|
| Codeine phosphate | 0.1 | 100mg |
| Dihydrocodeine | 0.1 | 100mg |
| Hydromorphone | 5 | 2mg |
| Methadone | * | * |
| Morphine | 1 | 10mg |
| Oxycodone | 1.5 | 6.6mg |
| Tapentadol | 0.4 | 25mg |
| Tramadol | 0.1 | 100mg |

** The relative potency of **methadone** depends on the starting dose and the duration of administration. Conversions to and from methadone should always be undertaken with specialist advice*

## Transdermal buprenorphine changed at weekly intervals

| | 5 microgram/hr | 10 microgram/hr | 20 microgram/hr |
|---|---|---|---|
| Codeine phosphate (mg/day) | 120mg | 240mg | |
| Morphine sulphate (mg/day) | 12mg | 24mg | 48mg |

| Fentanyl patch strength (microgram/hr) | Oral morphine (mg/day) |
|---|---|
| 12 | 30 |
| 25 | 60 |
| 50 | 120 |
| 75 | 180 |
| 100 | 240 |

Ref: Opioid Aware, Faculty of Pain Medicine

**RISK OF HARM**

**Patient factors:** Pregnancy, age ≥65, anxiety or depression, overdose history, personal or family history of alcohol, substance/opioid misuse, renal and hepatic impairment, COPD or underlying respiratory conditions.
**Drug factors:** Multiple opioids, multiple formulations of opioids, more potent opioids, concurrent prescriptions of benzodiazepines/CNS depressants.

- Dosages ≥ 120 mg oral MED/d the risk of harm is substantially increased without increased benefit.
- Opioid related overdose risk is dose-dependent.
- Dosages of 50-<100 mg MED/d increases the risk for opioid overdose by factors of 1.9 to 4.6 compared with 1-<20 mg MED/d.
- Dosages ≥ 100 mg MED/d increases the risk of overdose significantly: 2.0-8.9 compared with 1-<20 mg MED/d.

**DRIVING**

- Patients may be particularly vulnerable to impairment when first starting a pain medication, following dose adjustments (up or down), when another drug is added or opioid taken in conjunction with alcohol.
- All opioid medicines have the potential to impair driving. A patient on high dose morphine (around 200-220 mg/ 24 hours) driving could be as impaired as someone with blood alcohol around the level above which it is illegal to drive. Alcohol and sedatives may impair driving at a lower morphine dose.

**RECOMMENDATIONS**

Undertake polypharmacy medication review, assess whether benefits outweigh risks and whether opioid trial goals are still being met. Consider opioid tapering and discontinuation.
There may be a role for medium term, low dose opioid therapy in carefully selected patients who can be monitored. Provide patient information leaflets.

**References:**
1. Opioids Aware 2. CDC Guidelines for Prescribing Opioids for Chronic Pain United States 2016, 3. IASP Statement on Opioids 2018

Produced by the WSCCG Medicines Management Team and West Suffolk Integrated Pain Management Service.
Version 1 March 2018. Review Date March 2020.

# Appendix 5 Resources for Patient

**> Patient information resources-Chronic pain management British Pain Society**
https://www.britishpainsociety.org/people-with-pain/suggested-reading-list/

**> Living with Persistent Pain in Wales**
https://gov.wales/sites/default/files/publications/2019-05/living-with-persistent-pain-in-wales.pdf.

**> Supporting people with chronic pain in self-management**
https://www.nhsfife.org/services/all-services/pain-management-service/.

**> Drugs and driving: the law**
https://www.gov.uk/drug-driving-law

# Clinical Opiate Withdrawal Scale (COWS)

**Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.**

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

| | Times: _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| **Resting Pulse Rate**: (record beats per minute)<br>*Measured after patient is sitting or lying for one minute*<br>0 pulse rate 80 or below<br>1 pulse rate 81-100<br>2 pulse rate 101-120<br>4 pulse rate greater than 120 | | | | |
| **Sweating:** *over past ½ hour not accounted for by room temperature or patient activity.*<br>0 no report of chills or flushing<br>1 subjective report of chills or flushing<br>2 flushed or observable moistness on face<br>3 beads of sweat on brow or face<br>4 sweat streaming off face | | | | |
| **Restlessness** *Observation during assessment*<br>0 able to sit still<br>1 reports difficulty sitting still, but is able to do so<br>3 frequent shifting or extraneous movements of legs/arms<br>5 Unable to sit still for more than a few seconds | | | | |
| **Pupil size**<br>0 pupils pinned or normal size for room light<br>1 pupils possibly larger than normal for room light<br>2 pupils moderately dilated<br>5 pupils so dilated that only the rim of the iris is visible | | | | |
| **Bone or Joint aches** *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*<br>0 not present<br>1 mild diffuse discomfort<br>2 patient reports severe diffuse aching of joints/ muscles<br>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort | | | | |
| **Runny nose or tearing** *Not accounted for by cold symptoms or allergies*<br>0 not present<br>1 nasal stuffiness or unusually moist eyes<br>2 nose running or tearing<br>4 nose constantly running or tears streaming down cheeks | | | | |

| | | | | |
|---|---|---|---|---|
| **GI Upset**: *over last ½ hour*<br>0 no GI symptoms<br>1 stomach cramps<br>2 nausea or loose stool<br>3 vomiting or diarrhea<br>5 Multiple episodes of diarrhea or vomiting | | | | |
| **Tremor** *observation of outstretched hands*<br>0 No tremor<br>1 tremor can be felt, but not observed<br>2 slight tremor observable<br>4 gross tremor or muscle twitching | | | | |
| **Yawning** *Observation during assessment*<br>0 no yawning<br>1 yawning once or twice during assessment<br>2 yawning three or more times during assessment<br>4 yawning several times/minute | | | | |
| **Anxiety or Irritability**<br>0 none<br>1 patient reports increasing irritability or anxiousness<br>2 patient obviously irritable anxious<br>4 patient so irritable or anxious that participation in the assessment is difficult | | | | |
| **Gooseflesh skin**<br>0 skin is smooth<br>3 piloerrection of skin can be felt or hairs standing up on arms<br>5 prominent piloerrection | | | | |
| **Total scores**<br><br>**with observer's initials** | | | | |

**Score:**
**5-12 = mild;**
**13-24 = moderate;**
**25-36 = moderately severe;**
**more than 36 = severe withdrawal**

# Appendix 7 Treatment of Opioid Withdrawal Symptoms

**Please see your local health board Opioid withdrawal treatment guidelines and BNF**

Acute flare ups: (if no contraindication) Ibuprofen 200-400mg oral, 6 hourly or Diclofenac sodium 50 mg 8 hrly Plus a proton pump inhibitor (Omeprazole 20 mg or Lansoprazole 30 mg).

Paracetamol 1 gm 6 hrly upto max of 4 gm/day (decrease dose in high risk cases).

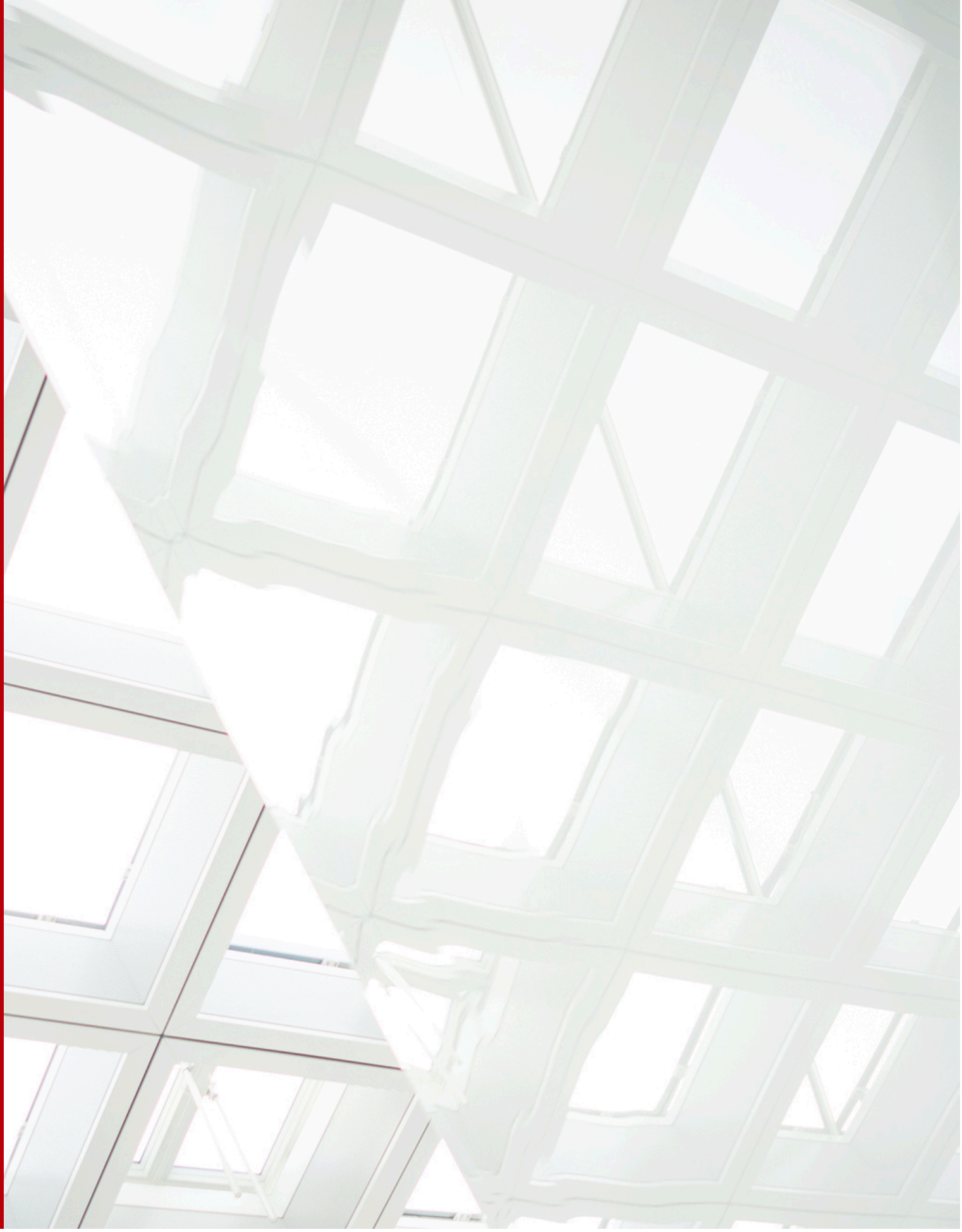
Diarrhoea: Oral Loperamide 4 mg oral stat and then PRN 2 mg upto max of 16 mg/day

Abdominal cramps: Hyoscine butyl bromide (Buscopan) IV or IM 20 mg as PRN max 80mg in 24 hours

Sleep problems: Zopiclone 3.75-7.5mg. Do not prescribe a benzodiazepine. Advise on sleep habits and relaxation strategies.

Lofexidine 0.2mg-0.4 mg orally, 2 - 4hourly, up to maximum of 2.4 mg in 24 hours. Monitor BP and PR. Withhold if SBP<90 and Pulse Rate <50 until back to normal. If it is on for long time, reduce slowly due to risk of rebound hypertension if stopped suddenly.

Nausea and Vomiting: Metoclopramide 10 mg oral or IM or Slow IV 8 hourly.



**Welsh Pain Society**

**10th November 2022 V2**